Statewide Transformation Initiative
Mental Health Benefit Package Design
Final Report

Community Support Agency (CSA)
Certification Excerpt

submitted to

The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division

July 2007

TriWest Group
6549 First Avenue NW
Seattle, WA 98117

Excerpts Pertinent To Community Support Agency (CSA) Certification

System Level Recommendations for Promoting Best Practices

BP Recommendation #4: Ground the promotion of specific best practices within a broader Evidence Based Culture. Partly in response to the growing recognition that efficacy research provides an insufficient base on which to build policy decisions regarding public mental health benefits, and partly in order to support the successful implementation of EBPs, increasing attention is turning to the need for system and organizational infrastructures that will support the implementation, broad dissemination, and ongoing scrutiny of evidence-based practices. Such infrastructures involve the policy, procedural, and funding mechanisms to sustain evidence-based interventions, and they need to be based in system and organizational cultures and climates that value the use of information and data tracking as a strategy to improve the quality of services and increase the likelihood of achieving desired outcomes (a data and learning-centered construct implicit in an array of broader constructs, including "learning organizations," "continuous quality improvement," and others).

Increasingly researchers[1] use the term "evidence based culture" to describe the constellation of policy, procedural, and funding mechanisms that, in concert with a favorable culture and climate, support successful practice.[2] An evidence based culture includes the following:

- Involves all levels of the system – state and regional administrators, provider program managers, clinical supervisors, clinicians, consumers, and family members – in the implementation process;
- Begins with a thorough understanding of the current treatment system, the interventions that are utilized, the need for coordination with other human service systems (e.g., chemical dependency, child welfare, juvenile justice, criminal justice, primary care) and the outcomes being achieved;
- Includes a systematic approach to reviewing available evidence and recommending changes in intervention strategies as appropriate;
- Supports a reimbursement rate commensurate with the level of work required to implement new interventions (including any impact on clinic-based productivity expectations) so that all allowable provider costs are covered;

[1] Dixon, G.D. (2003). Evidence-based practices. Part III. Moving science into service: Steps to implementing evidence-based practices. Tallahassee, FL: Southern Coast Beacon (a publication of the Southern Coast ATTC). Available online at http://www.scattc.org/pdf_upload/Beacon003.pdf .

Barwick, M.A., Boydell, K.M., Stasiulis, E., Ferguson, H.B., Blase, K, & Fixsen, D. (2005). Knowledge transfer and implementation of evidence-based practices in children's mental health. Toronto, Ontario: Children's Mental Health Ontario.

[2] Rivard, J., Bruns, E., Hoagwood, K., Hodges, K., & Marsenich, L. (2006). Different Strategies for Promoting and Institutionalizing an Evidenced-Based Culture. In C. Newman, C. Liberton, K. Kutash, & R. M. Friedman (Eds.), The 19th Annual Research Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

- Provides reimbursement for the training and clinical supervision, as well as the administrative overhead required by health plans and providers, that are essential to implementation of evidence-based practices;
- Creates and maintains data collection and reporting mechanisms that will document evidence-based practice results;
- Develops and supports policies that facilitate adoption and implementation of evidence-based practices;
- Supports bi-directional communication between researchers and clinicians;
- Promotes an appropriate balance between fidelity and adaptation; and,
- Uses outcome data to drive systems change.

In keeping with this line of thought, members of the National EBP Consortium[3] expressed much concern that the increasingly common approach taken by many states of mandating the use of specific EBPs does not necessarily lead to improved outcomes and does little to help agencies, provider organizations, and communities understand how best to select and implement effective interventions. In order to make the most of the movement toward evidence-based practice at the federal, state, and local levels, discussions are increasingly turning towards a systematic process through which decisions are made at the community level so that communities are supported to select, implement, and sustain effective practices. Such a process ideally is inclusive, strategic, and driven by the needs, strengths, and local cultures of the consumers, families, and communities served. The efforts of the states of New York[4] and Hawaii[5] to implement EBPs statewide offer best practice examples of states working towards an evidence-based culture, and are discussed in more detail in our February 2007 preliminary report.

Washington has taken important steps toward promotion of an evidence-based culture across DSHS. The work of the federally funded Mental Health Transformation grant has helped contribute to this. For example, the Client Services Data Base developed by the Research and Data Analysis Division of DSHS can serve as a basis for a broader evidence-based culture at DSHS by integrating available administrative data from several state and local agencies into a common data set, thereby allowing system monitoring, cross-agency management reports, and research across agencies. The project has substantial support from the Mental Health Transformation grant. The data base is already developed to a significant extent and is being fully developed over a three to four year time line, and will capture data from CY 2004 forward.

[3] Rivard, J. et al. (2006).
[4] Carpinello, S. et al. (2002). New York State's Campaign to Implement Evidence-Based Practices for People with Serious Mental Disorders. Psychiatric Services, (53) 2.
[5] Daleiden, E.L. & Chorpita, B.F. (2005). From data to wisdom: Quality improvement strategies supporting large-scale implementation of evidence based services. In B.J. Burns & K.E. Hoagwood (Eds.), (2005). Evidence-Based Practice, Part II: Effecting Change, Child and Adolescent Psychiatric Clinics of North America, 14, 329-349.

BP Recommendation #6: Develop encounter coding protocols to allow MHD and RSNs to track the provision of other best practices.

One of the challenges that MHD faces in promoting best practices is determining the current utilization of such services. Generally, the service codes currently used for encounter reporting lack the specificity needed to differentiate best practices. For example, provision of Individual Psychotherapy 40-50 minutes (CPT Code 90806) could represent any of a number of best practices (such as Cognitive Behavior Therapy, Trauma-Focused Cognitive Behavior Therapy, or Dialectical Behavior Therapy) or an undifferentiated therapy without a documented evidence base. This lack of specificity complicates the promotion of best practices by providing the same reimbursement across different types of best practices, providing the same reimbursement for generic and best practices, limiting the ability of MHD to monitor best practice availability, and limiting the ability of actuarial analysis to factor in the additional costs incurred by the delivery of best practices that require specialized training, reduced productivity, and/or fidelity monitoring.

Therefore, we recommend that MHD develop additional encounter coding modifiers so that all best practices of interest within the public mental health system are tracked, using a mix of coding strategies, including procedure codes, procedure code modifiers, and program codes identifying specific groups of individual providers within agencies.[6] In addition, protocols governing the use of these codes will need to be defined and enforced. For example, use of the Multisystemic Therapy (MST) code H2033 should be limited only to certified MST teams. Enforcement of the use of specialty codes for services such as MST with formal certification programs will be simpler than enforcement of the use of specialty codes for more widely available services such as Cognitive Behavior Therapy (CBT). While tracking all of the services would be of value, MHD may want to prioritize for initial development and piloting those services for which codes and oversight protocols are more readily available (such as MST, Wraparound, ACT).

Some best practices already have adequate coding modifiers. These include:

- Mental Health Clubhouse Services – H2031,[7]
- Therapeutic Psychoeducation – H2027, S9446, and H0025.[8]

Others are allowable under current codes, but would require the use of a modifier to differentiate them from more generic services. These include:

- Multiple types of Peer Support could be tracked, including:

[6] These modifiers will need to comply with the standards of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as do all current electronic reporting protocols.

[7] Some stakeholders have raised the question as to whether ICCD-certified clubhouse services should be differentiated from those that are not formally certified. Given that clubhouse services are generally provided by agencies, it seems that ICCD certification could be tracked by agency codes rather than separate modifiers. However, a modifier could be added if desired, similar to the recommendations for other services types below.

[8] Given that there are multiple coding options for Therapeutic Psychoeducation, we would further recommend either limiting the allowable codes to one (e.g., H2027) or providing additional guidance to help RSNs and providers know which of the three codes to use in which circumstances. If the three cannot be distinguished clearly, we recommend reducing the number of codes.

- Drop-in centers,
- Encounters involving WRAP activities,
- Individual encounters, and
- Group encounters.

Recommended Priority Best Practices

Consumer and Family Run Services

The State of Arizona has developed a certification model for providers of "non-licensed behavioral health services," referring to this subgroup of providers as Community Service Agencies (CSAs). According to Arizona's services guide for behavioral health services,[9] CSAs are able to provide a range of services that do not require delivery by a licensed behavioral health clinician, including psychosocial rehabilitation, peer support, family support, day programs, respite care, and transportation services.[10] While Arizona does not include Peer Support in its Medicaid State Plan, CSA staff members providing other services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided.

Arizona offers this provider type under its 1115 waiver authority. We recommend that Washington State establish a CSA provider type under an amended 1915(b) waiver authority that is allowed to provide a narrow array of services, at least at the start. The primary service type that we recommend covering in Washington is Peer Support. Experience, supervision, and documentation requirements in Washington's State Plan and state-level regulations would need to be met. The State Plan currently requires that Peer Support be provided by "peer counselors", but appropriately leaves the definition of standards for peer counselors to state-level regulations. Washington may also explore allowing CSAs to provide other services, such as Wraparound Service Coordination or Respite, that do not require provision of the service by a licensed mental health clinician under the State's current benefit design. Under a 1915(b) waiver, covered State Plan services may be provided by an alternative provider type such as a CSA as long as the staff providing the service meet the same criteria that staff in a State Plan defined provider setting (i.e., Community Mental Health Agency staff) would meet. For example, Pennsylvania currently uses its 1915 waiver authority to cover outpatient services under its Clinic Services option provided in long-term residential facilities, even though that provider type would not be eligible outside the waiver to deliver such services.

[9] AHCCSS Behavioral Health Services Guide: 2007. Arizona Health Care Cost Containment System: Phoenix, AZ. Downloaded at: http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/BehavioralHealthServicesGuide.pdf

[10] Keep in mind that the Arizona definitions of these services vary from those of Washington. Differences between Arizona's covered Medicaid benefits and those of Washington State are described later in this report.

For the cost calculations in this report, we are estimating costs for Peer Support delivered by consumer and family-run CSAs. Staff delivering Peer Support in CSAs would need to meet the same criteria as staff delivering the service in a Community Mental Health Agency (CMHA) setting, specifically being a certified peer specialist. Washington's Peer Support Medicaid State Plan modality allows a wide range of services to be delivered by peer specialists, including: "Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance each consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc)." Washington is the only state of which we are aware that has successfully expanded the model to include family members of child and adolescent consumers.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.[11] Washington's definition of Peer Support allows such embedding, and it also allows for Peer Support in particular settings such as the following:

- **Drop-in Centers.** Drop-in centers originated in the late 1980s to provide consumers of mental health services with opportunities for socialization, education, and emotional support as an alternative to traditional mental health treatment. Today, the concept of drop-in centers has evolved to be "peer support centers," with a mission to provide a place where consumers can direct their own recovery process and, often, to serve as a complement to other mental health services.[12] Although drop-in centers generally are run by consumers, many maintain some kind of collaborative relationship with a mental health provider agency.[13] Studies suggest that experience at a drop-in center is associated with high satisfaction, increased quality of life, enhanced social support, and problem solving.[14]
- **Wellness Recovery Action Plans (WRAP).** Washington's Peer Support certification training also incorporates training in the Wellness Recovery Action Plan (WRAP) approach, a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. At least one study of WRAP found significant

[11] Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E. and Brown, C. (1995). Consumers as peer specialist on intensive case management teams: Impact on client outcomes. Psychiatric Services, 46, 1037-1044.
[12] Technical Assistance Guide: Consumer-run Drop-In Centers. National Mental Health Consumers' Self-Help Clearinghouse.
[13] Kaufmann, C.L., Ward-Colasante, C., and Farmer, J., (1993). Development and Evaluation of Drop-In Centers Operated by Mental Health Consumers. Hospital and Community Psychiatry 44 (7): 675-678.
[14] Schell, B. (2003). Program Manual for a Consumer-Run Drop-In Center based on the Mental Health Client Action Network in Santa Cruz, CA. Prepared for SAMHSA COSP-MultiSite Study, FliCA site. Citing Mowbray, C. T. and Tan, C. (1992). Evaluation of an Innovative Consumer-Run Service Model: The Drop-In Center. Innovations & Research 1(2):19-24.

increases in consumers' self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.[15] Another widely-cited study found increases in consumers' self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.[16]

- **Wraparound Service Coordination.** Other states have also begun to utilize family members of children with SED as facilitators for Wraparound Service Coordination. Wraparound is designed to provide a set of individually tailored services to a child and family using a team-based planning process. Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.[17] In our discussions with key informants, they have noted that Wraparound is generally more successful when delivered by BA-level paraprofessionals rather than MA-level clinicians.[18] Projects are also beginning to draw on family members for this service in Colorado and Maryland.

Based on data from a leading CSA provider in Arizona,[19] we are estimating that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered currently through a CMHA. We therefore believe that the service costs for this modality were already added to the system based on Washington's 2005 actuarial study.[20] However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations.

---

[15] Vermont Recovery Education Project, cited in Cook, J., Mental Illness Self-Management through Wellness Recovery Action Planning (n.d.), retrieved at www.copelandcenter.com.

[16] Buffington E., (2003). Wellness Recovery Action Plan: WRAP evaluation, State of Minnesota. Minneapolis, MN: Mental Health Consumer/Survivor Network of Minnesota.

[17] 2004 Wraparound Milwaukee Report. http://www.co.milwaukee.wi.us/display/router.asp?docid=7851.

Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). The Comparative Costs and Benefits of Programs to Reduce Crime. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). Toward a better understood and implemented Wraparound. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services. 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources. Research and Training Center on Family Support and Children's Mental Health.

[18] B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007.

[19] G. Johnson, Executive Director, META , Phoenix, AZ, Personal Communication, multiple dates in May 2007.

[20] Barclay, T. & Knowlon, S. (June 2, 2005). State of Washington, Department of Social & Health Services, Mental Health Division, Actuarial Rate Certification. Appendix 11, page 150. Milliman, Inc.

The cost to provide Peer Support services without robust Center of Excellence (COE) supports is currently built into the rates paid to RSNs. In addition, Washington uses approximately $150,000 in federal block grant funds to pay for the current peer specialist certification program. We estimate that the costs to provide a COE adequate to support statewide implementation of Peer Support to be approximately $425,000 per year. These costs could be passed on to the Medicaid program in the form of certification expenses for peer specialists. Assuming that 25 peer specialists are trained per session and assuming a total of six sessions per year, this would translate into 150 peer specialists trained a year. A $3,000 charge per specialist would cover these costs.

By expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers), the supports could help bring Peer Support service delivery up to the levels factored into the current rates. Assuming that happened, $215,000 in state expenditures (to cover the Medicaid match) would be needed as noted in the table below. Further assuming that freeing up the $150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the additional costs would be reduced to $65,000 a year.

Consumer-Run Peer Support Center of Excellence Cost Estimates		
Variables	**Costs**	**Funding Sources**
Estimated Annual Cost of Peer Support Center of Excellence	$425,000	$215,000 Federal $215,000 State Match
Annual Cost of Current Peer Support Certification Program	$150,000	Federal Block Grant
Additional Costs to State if Federal Block Grant Funds Can Be Shifted	$ 65,000	Additional State Match

Appendix Two: Detailed Comparisons with Other States (Arizona, Colorado, New Mexico, and Pennsylvania)

Analysis by Modality. We also conducted a detailed analysis by modality focused on how Washington's State Medicaid Plan, managed care waiver, and accompanying encounter reporting guide come together to define its covered Medicaid mental health services, contrasting this with how the State Plans, managed care waivers, and encounter reporting guides of the other four states define their benefits. For the current report, we analyzed Washington's modalities arranged in the three groupings discussed earlier (Care in 24 Hour Settings, Traditional Outpatient Modalities, and Non-Traditional Outpatient Modalities). In addition to the 18 Rehabilitative Services modalities, we also analyzed within these three groupings the three other Medicaid modalities coordinated by RSNs (Inpatient Hospital Services, Under 21 Inpatient Services, and Physician Services) and the three B-3 services.

Non-Traditional Outpatient Modalities. Several issues were identified related to non-traditional outpatient services and supports, including:

- Washington's Peer Support modality is very broad and superior to those of most of the comparison states (other than AZ), which either currently do not cover this service or do so only under their waiver. However, the requirement that the service be provided by a CMHA complicates the peer-nature of service delivery by requiring that it take place in a professional setting. Washington's waiver could allow delivery of this service in other defined consumer and family-run settings similar to those allowed under Arizona community support agency provider type. While this adds to the administrative burden of provider oversight by the State and managed care organizations, it also allows delivery of these peer-run services by less costly providers. In addition, the limit on use of this service to four hours per enrollee per day should be able to be exceeded as needed by RSNs as a cost-effective alternative under the State's 1915(b) waiver authority.
- Mental Health Clubhouses must conform to ICCD guidelines under the State's current B-3 definition. While the comparison states do not include this requirement, by doing so Washington ensures a higher quality of service. Furthermore, less formal drop-in services could potentially be covered under the current Peer Support modality and could be more widely covered if Peer Support availability was expanded under the waiver to include peer-run agencies.
- The definition of Therapeutic Psychoeducation is also quite broad and generally superior to those of the comparison states. Limiting the provision of this service to CMHAs does potentially increase costs and limit provision of the service by peer-run organizations. The approaches discussed above for potentially expanding Peer Support to be provided by peer-run organizations could also apply in the case of psychoeducation.

Appendix Eight: Comprehensive Cost Calculations for Prioritized Best Practices

Consumer and Family Run Services

The State of Arizona has developed a certification model for providers of "non-licensed behavioral health services," referring to this subgroup of providers as Community Service Agencies (CSAs). According to Arizona's services guide for behavioral health services,[21] CSAs are able to provide a range of services that do not require delivery by a licensed behavioral health clinician, including psychosocial rehabilitation, peer support, family support, day programs, respite care, and transportation services.[22] CSA staff members providing services covered by Medicaid must meet the same criteria that staff in more traditional provider settings must meet (such as experience and supervision requirements) for any specific service type provided.

Arizona offers this provider type under its 1115 waiver authority. We recommend that Washington State establish a CSA provider type under an amended 1915(b) waiver authority that is allowed to provide a narrow array of services, at least at the start. The primary service type that we recommend covering is Peer Support. Experience, supervision, and documentation requirements in Washington's State Plan and state-level regulations would need to be met. The State Plan currently requires that Peer Support be provided by "peer counselors", but appropriately leaves the definition of standards for peer counselors to state-level regulations. Washington may also explore allowing CSAs to provide other services, such as Wraparound Service Coordination or Respite, that do not require provision of the service by a licensed mental health clinician under the State's current benefit design. Under a 1915(b) waiver, covered State Plan services may be provided by an alternative provider type such as a CSA as long as the staff providing the service meet the same criteria that staff in a State Plan defined provider setting (i.e., Community Mental Health Agency staff) would meet. Pennsylvania currently uses its 1915 waiver authority to cover outpatient services under its Clinic Services option provided in long-term residential facilities, even though that provider type would not be eligible outside the waiver to deliver such services.

For the cost calculations in this report, we are estimating costs for Peer Support delivered by consumer and family-run CSAs. Staff delivering Peer Support in CSAs would need to meet the same criteria as staff delivering the service in a Community Mental Health Agency (CMHAs) setting, specifically being a certified peer specialist. Washington's Peer Support Medicaid State Plan modality allows a wide range of services to be delivered by peer specialists, including: "Self-help support groups, telephone support lines, drop-in centers, and

[21] AHCCCS Behavioral Health Services Guide: 2007. Arizona Health Care Cost Containment System: Phoenix, AZ. Downloaded at: http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/BehavioralHealthServicesGuide.pdf

[22] Keep in mind that the Arizona definitions of these services vary from those of Washington. Differences between Arizona's covered Medicaid benefits and those of Washington State are described later in this report.

sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance each consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc)." Washington is the only state of which we are aware that has successfully expanded the model to include family members of child and adolescent consumers.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.[23] Washington's definition of Peer Support allows such embedding, and it also allows for Peer Support in particular settings such as drop-in centers.

Drop-in centers originated in the late 1980s to provide consumers of mental health services with opportunities for socialization, education, and emotional support as an alternative to traditional mental health treatment. Today, the concept of drop-in centers has evolved to be "peer support centers," with a mission to provide a place where consumers can direct their own recovery process and, often, to serve as a complement to other mental health services.[24] Although drop-in centers generally are run by consumers, many maintain some kind of collaborative relationship with a mental health provider agency.[25] Studies suggest that experience at a drop-in center is associated with high satisfaction, increased quality of life, enhanced social support, and problem solving.[26]

Washington's Peer Support certification training also incorporates training in the Wellness Recovery Action Plan (WRAP) approach, a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. At least one study of WRAP found significant increases in consumers' self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.[27] Another widely-cited study found increases in consumers' self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are

[23] Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E. and Brown, C. (1995). Consumers as peer specialist on intensive case management teams: Impact on client outcomes. Psychiatric Services, 46, 1037-1044.
[24] Technical Assistance Guide: Consumer-run Drop-In Centers. National Mental Health Consumers' Self-Help Clearinghouse.
[25] Kaufmann, C.L., Ward-Colasante, C., and Farmer, J., (1993). Development and Evaluation of Drop-In Centers Operated by Mental Health Consumers. Hospital and Community Psychiatry 44 (7): 675-678.
[26] Schell, B. (2003). Program Manual for a Consumer-Run Drop-In Center based on the Mental Health Client Action Network in Santa Cruz, CA. Prepared for SAMHSA COSP-MultiSite Study, FliCA site. Citing Mowbray, C. T. and Tan, C. (1992). Evaluation of an Innovative Consumer-Run Service Model: The Drop-In Center. Innovations & Research 1(2):19-24.
[27] Vermont Recovery Education Project, cited in Cook, J., Mental Illness Self-Management through Wellness Recovery Action Planning (n.d.), retrieved at www.copelandcenter.com.

aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.[28]

Other states have also begun to utilize family members of children with SED as facilitators for Wraparound Service Coordination. Wraparound is designed to provide a set of individually tailored services to a child and family using a team-based planning process. Wraparound is not a treatment in itself, but is instead a coordinating intervention to ensure the child and family receives the most appropriate set of services possible.[29] In our discussions with key informants, they have noted that Wraparound is generally more successful when delivered by BA-level paraprofessionals rather than MA-level clinicians.[30] Projects are also beginning to draw on family members for this service in Colorado and Maryland. Additional costs for CSAs to provide Wraparound Service Coordination have not been incorporated into the rates projected below for CSAs. However, the later section below estimating additional costs to be added for Wraparound would also cover the costs of any family-run CSAs offering the service.

Cost per Unit. Based on data from a leading CSA provider in Arizona,[31] we are estimating that the cost per unit of Peer Support delivered through a CSA is comparable to that delivered currently through a CMHA. We therefore believe that the service costs for this modality were already added to the system based on Washington's 2005 actuarial study.[32] However, adequate costs to promote the infrastructure necessary to develop CSAs were not. This may very well be a contributing reason to why current levels of peer support provision by most RSNs remain below expectations, as discussed in more detail below.

The total costs add up to $425,000 per year. These costs could be passed on to the Medicaid program in the form of certification expenses for peer specialists. Assuming that 25 peer specialists are trained per session and assuming a total of six sessions per year, this would

---

[28] Buffington E., (2003). Wellness Recovery Action Plan: WRAP evaluation, State of Minnesota. Minneapolis, MN: Mental Health Consumer/Survivor Network of Minnesota.

[29] 2004 Wraparound Milwaukee Report. http://www.co.milwaukee.wi.us/display/router.asp?docid=7851.

Aos, S., Phipps, P. Barnoski, R., & Lieb, R. (2001). The Comparative Costs and Benefits of Programs to Reduce Crime. Olympia: Washington State Institute for Public Policy.

Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group. (2004, March 1). Toward a better understood and implemented Wraparound. 17th Annual System of Care Research Conference, Tampa FL.

Burns, B.J., Hoagwood, K., & Maultsby, L.T. (1998). Improving outcomes for children and adolescents with serious emotional and behavioral disorders: Current and future directions. In Epstein, M., Kutash, K., & Duchnowski, A. (Eds.). Outcomes for Children and Youth with Behavioral and Emotional Disorders and their Families. Austin, TX: Pro-Ed.

Hoagwood, K., Burns, B., Kiser, L., et al. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services. 52:9, 1179-1189.

Walker, Janet S., Schutte, K. (2003). Individualized Service/Support Planning and Wraparound: Practice-Oriented Resources. Research and Training Center on Family Support and Children's Mental Health.

[30] B. Kamradt, Executive Director, Wraparound Milwaukee, Personal Communication, June 12, 2007.

[31] G. Johnson, Executive Director, META , Phoenix, AZ, Personal Communication, multiple dates in May 2007.

[32] Barclay, T. & Knowlon, S. (June 2, 2005). State of Washington, Department of Social & Health Services, Mental Health Division, Actuarial Rate Certification. Appendix 11, page 150. Milliman, Inc.

translate into 150 peer specialists trained a year. A $3,000 charge per specialist would cover these costs.

Factoring those costs into the Medicaid payments made to each RSN would require the costs to be added to the fees paid per hour of Peer Support delivered. In CY 2006, 75,929 hours of Peer Support were delivered statewide.[33] Factoring the costs of an expanded Peer Support COE across each hour of service would add $5.60 to the cost of each. Factoring this across the Medicaid eligible population in CY2006 of 1,088,078 yields an additional per member per month factor of $0.033.

Anticipated Utilization and Utilization per User. As noted previously, costs for Peer Support utilization were added to RSN rates following the last rate certification. However, as of CY2006, only seven RSNs were delivering Peer Support services. In CY2006, Statewide penetration for Peer Support was 1,924 consumers or 0.18% of the Medicaid eligible population. Six RSNs provided no Peer Support. Across those that did, penetration ranged from a low of 0.01% to a high of 0.72%. Based on this, we believe that current utilization is below the amount factored into the rates following the 2005 actuarial study.

Infrastructure Support Costs per Unit. Currently Washington operates a certification program for peer specialists which provides multiple sessions per year and trains adult and family peer specialists together in a single group. The cost to operate this program is approximately $150,000 per year and covers primarily the costs of training and limited ongoing coaching. This core capacity would have to be significantly expanded in order to support a true Center of Excellence for Peer Support. Recommended enhancements include:

- **Developing separate training tracks for adults and children –** The Peer Support needs of adults and their families and those of the parents and caregivers of children with mental health needs are quite different. Multiple stakeholders we spoke with commented on the need to develop separate tracks for adult and child peer specialists. We estimate that this would increase the costs of operating the COE by one FTE (which we estimate at $50,000 in fully loaded costs for a peer specialist training supervisor for children and families) and three additional trainings sessions per year (which we estimate at $20,000 per session).
- **Adding an evaluation capacity –** We recommend adding an evaluation capacity so that the COE includes the capacity to track fidelity and outcomes. We estimate the costs of a staff member with sufficient evaluation skills to be $65,000 per year in fully loaded costs.
- **Adding capacity to support CSA infrastructure –** All of the informants we interviewed in Washington and other states underscored the challenges in supporting consumer and family run agencies, including coaching, administrative support, and targeted grants to support capacity. We estimate that the costs of adding this capacity to the current Peer Support infrastructure would involve one FTE (estimated at $50,000 in fully loaded costs) and an additional $50,000 in targeted grants to support CSA development.

[33] Statewide, only seven RSNs delivered Peer Support services. Data was provided by K. Weaver-Randall, Personal Communication, July 23, 2007.

Anticipated Cost Offsets. We are not estimating any additional cost offsets to the system other than those already incorporated into the current rates. However, by incorporating the costs of the current certification program into the Medicaid rates, the State will realize a cost offset through the additional Federal Financial Participation (FFP). The additional FFP would cover much of the additional costs of retooling the program to have separate adult and child-focused tracks.

Potential Annual Expenditures Needed. The cost to provide Peer Support services without robust COE supports is currently built into the rates paid to RSNs. In addition, Washington uses approximately $150,000 in federal block grant funds to pay for the current peer specialist certification program. By expanding the current peer specialist certification program into a COE able to promote the provision of Peer Support across an expanded group of potential providers (both CMHAs and the new CSA providers), the supports could help bring Peer Support service delivery up to the levels factored into the current rates. Assuming that happened, $215,000 in state expenditures (to cover the Medicaid match) would be needed as noted in the table below. Further assuming that freeing up the $150,000 in federal block grant funding currently spent on Peer Support training could free up State General Funds currently going to pay for other purposes (and thereby allow these State General Funds to be shifted to other mental health priorities), the additional costs would be reduced to $65,000 a year.

	Costs	Funding Sources
Estimated Annual Cost of Peer Support Center of Excellence	$425,000	$215,000 Federal $215,000 State Match
Annual Cost of Current Peer Support Certification Program	$150,000	Federal Block Grant
Additional Costs to State if Federal Block Grant Funds Can Be Shifted	$ 65,000	Additional State Match

The table on the following page summarizes all of the factors included in the costs analysis for statewide Peer Support implementation through Community Service Agencies and CMHAs.

Peer Support Cost Factors Overview		
Medicaid Modality / Service Code	**H0038 – Peer Support**	
Subset:	May want to develop additional modifiers to capture different types of interventions: WRAP activities, drop-in centers, individual interventions, group interventions	
Eligibility Groups:	**Adult Disabled, Child Disabled, Adult Non-Disabled**	
Monthly Cost Per Member Per Month (PMPM):		
Adult Disabled:	$ 0.87	2005 Actuarial Study
Child Disabled:	$ 1.39	2005 Actuarial Study
Adult Non-Disabled:	$ 0.17	2005 Actuarial Study
Center of Excellence Estimate:	$ 0.033	$425,000 annual cost divided across 1,088,078 eligibles per month
Expected Additional Cost Offsets:	Not Applicable	Factored into current PMPM
ALOS:	Not Applicable	Factored into current PMPM
CY2006 Utilization:		
Statewide:	**1,924**	CY2006 data: 320 age 0-17, 1,502 age 18-59, 102 age 60+
Enrolled Members:	1,088078	CY2006: All enrollees
H0038 Penetration:	0.18%	
Clark RSN:	**497**	
Enrolled Members:	69,161	
H0038 Penetration:	0.72%	
Greater Columbia RSN:	**11**	
Enrolled Members:	164,010	
H0038 Penetration:	0.01%	
King County RSN:	**1,242**	
Enrolled Members:	228,680	
H0038 Penetration:	0.54%	
Northeast RSN:	**33**	
Enrolled Members:	16,623	
H0038 Penetration:	0.20%	
Peninsula RSN:	**16**	
Enrolled Members:	49,095	
H0038 Penetration:	0.03%	
Spokane RSN:	**66**	
Enrolled Members:	94,782	
H0038 Penetration:	0.07%	
Southwest RSN:	**59**	
Enrolled Members:	22,691	
H0038 Penetration:	0.26%	